PHILADELPHIA MEDICAL TIMES.

SATURDAY, FEBRUARY 8, 1873.

LECTURES

ON THE SURGERY OF THE NARES, LARYNX, AND TRACHEA.

BEING THE MÜTTER LECTURES FOR 1872.

Delivered before the College of Physicians of Philadelphia,

BY J. SOLIS COHEN, M.D.

Reported by R. M. BERTOLET, M.D.

(Continued from page 274.)

LECTURE II.

EXAMINATION OF THE LARYNGEAL IMAGE IN DETAIL.

HAVING in the preceding lecture considered the different methods employed in making laryngoscopic or rhinoscopic examinations, it remains for us to study the images of these parts as seen in the healthy state, before going to the consideration of morbid conditions and changes occurring in them.

We must content ourselves with referring the reader to any of the more extensive treatises upon anatomy for a detailed description of these parts; that of either Henle or Luschka will be found very complete so far as relates to the anatomy of the larynx.

The most conspicuous structure attracting attention in the laryngeal image is the epiglottis, whose free portion, jutting upwards from the base of the tongue, renders it easily recognized. Directing our attention to this cartilage, we perceive an anterior and a posterior surface, and an upper arching crest, frequently indented; from its lateral borders is given off on either side a pharyngo-epiglottic fold of mucous membrane, arching upwards and forwards to join the posterior palatine arch as it terminates in the lateral pharyngeal wall. As this fold leaves the epiglottis, we distinguish another and thicker fold, leaving the same point at nearly right angles, and stretching curvilinearly backwards to the arytenoid cartilages. This is the ary-epiglottic fold forming the superior free border of the quadrangular membrane of the larynx. The anterior or lingual surface of the epiglottis is seen to be slightly concave from above downwards, and strongly convex from side to side, while its posterior surface is concave and convex in the opposite directions. Upon observing the posterior or laryngeal surface of the epiglottis, we notice that it swells out abruptly into a considerable belly or pad, which tapers down to its point of attachment.

This tubercle or pad of the epiglottis, also known as the "cushion of the epiglottis," is formed chiefly by an aggregation of mucous glands and adipose tissue. It very often projects sufficiently to cut off the view of the anterior portions of the vocal cords attached to the intermediate plate of the thyroid cartilage below. The normal color of the pad is quite red; and by artificial illumination it will have a deeper color than by sunlight, a point to be borne in mind, lest the diagnosis of congestion be improperly made. Stretching from the middle line of the lingual surface of the epiglottis to the raphé of the tongue is seen the median glosso-epiglottic fold or frænulum of the epiglottis. It is a small, sharp-edged membranous fold, enclosing the glosso-epiglottic ligament, and serves to force the epiglottis to participate in the movements of the tongue. Upon each side of this fold, which is strongly raised when the tongue is protruded, there is seen an indentation, sometimes shallow, often deeply depressed. These are the *lingual sinuses*, termed the glosso-epiglottic fossæ or sinuses by some,—the valleculæ by others. When shallow, they gradually become lost in the lateral border of the tongue; but more frequently they are strongly depressed at the frænal outline, and, becoming less deeply marked on either side, are bounded exteriorly by a sharp fold of the mucous membrane of the sides of the tongue, called the lateral glosso-epiglottic fold. These lateral folds do not enclose any ligament, and, though generally found to exist post-mortem, are very frequently absent in the living organ. In the floor of these sinuses we are able sometimes to discern with the laryngoscope the position of the greater horn of the hyoid bone, which appears as a clear, longish-oval projection behind and extending outwards. These lingual sinuses often afford lodgment for articles of food and various foreign bodies, and they are not unfrequently the site of morbid processes, especially of tuberculous, scrofulous, or syphilitic ulcerations; cystic growths have also been seen in them. We have devoted considerable space to the apparently unimportant lingual surface of the epiglottis, but the importance of always examining it cannot be over-estimated, as there are a number of cases on record in which long-continued throat-disease had resisted topical applications to the larynx,—diseases which the laryngoscope revealed to be ulceration of these sinuses, soon healed by proper local treatment.

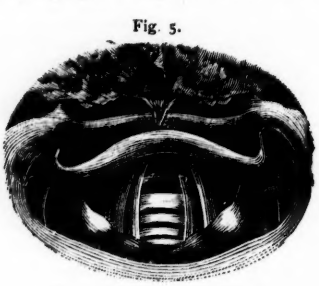
The color of the epiglottis is a light red, veiling a yellowish white, being less pronounced at its edge, where the color of the cartilage is more distinct,—much like the color of the conjunctival membrane of the eyelid, to which it was compared by Störk. Posteriorly the red deepens. The thickness of the epiglottis varies from a sharp thin edge—hardly a line—to a thick stump of several lines; and, when swollen, it may be as thick as a finger. It is also very variable in shape: sometimes it is long, narrow, and pointed; sometimes the sides roll in together posteriorly until they nearly touch; sometimes it is curled inwards with a contraction in the middle, which has been called the Omega-shaped epiglottis. This latter condition is either congenital or acquired by the contraction of cicatricial tissues. Ordinarily the epiglottis will be found to overlook the laryngeal entrance at an angle of from forty to sixty degrees; but it is sometimes depressed backwards much more, so that it may entirely cut off the view into the larynx.

Outside the ary-epiglottic fold, between it and the inner face of the thyroid, we see the triangular *pyramidal sinus*, which begins on each side of the free border of the epiglottis as a small, dark, deep

fossa, becoming more and more conical as it descends, until it is finally lost at one end of the transverse furrow marking the commencement of the œsophagus. The outer wall is formed by the inner face of the wing of the thyroid cartilage, and above this is the hyo thyroid membrane and then the hyoid bone; on the inner side is the quadrangular membrane, which forms a vertical angle anteriorly with the wing of the thyroid; and behind, it is bounded by the posterior wall of the pharynx. It is lined by the common pharyngeal mucous membrane, and along its angular floor there is a chain of glands often involved in disease of these parts. These pyramidal sinuses are sometimes entirely empty; sometimes they contain mucus, and sometimes a sort of cheesy deposit; they often afford a lodgment for foreign bodies, and they are frequently involved in pharyngeal troubles.

When the tongue is protruded and the epiglottis well raised (Fig. 5), we gain a view of the whole

Fig. 5.



The Laryngoscopic Image.

circumference of the superior laryngeal aperture. It is of a cordiform shape, wider in front than behind, sloping obliquely downwards, and terminating behind in the vertical inter-arytenoidal fissure. Its border in front is the free rim of the epiglottis; then, on either side, the ary-epiglottic fold, which arches backwards in the form of a bow until it reaches its arytenoidal attachment posteriorly, where it surrounds the rounded eminence of the cartilage of Santorini; and the two arytenoids, with their connecting muscle and mucous fold, complete the border posteriorly. The ary-epiglottic fold is divided into two unequal festoons by a swelling, in front of the Santorinian cartilage, enclosing the staff-like cartilage of Wrisberg, surrounded with glands and adipose tissue. The color of the ary-epiglottic folds has been well compared by Störk to that of the gums. The eminences of Wrisberg and Santorini are of a rather lighter color than the rest of the mucous membrane.

About half an inch below the superior aperture of the larynx are seen the *ventricular bands*, often still improperly designated as false vocal cords. They appear as broad mucous folds of a red color, and are formed by the mucous lining of the larynx folding under on itself, and leaving between it and the upper surface of the vocal cord of the same size—seen immediately below as a white, glistening band extending from before backwards—an oblong interval, which is the entrance into the Morgagnian ventricle of the larynx. By means of a deep inspiration, especially if short, sudden, and following vocalization, these ventricles can be rendered more distinct, and a separation of their walls be observed dilating the cavity. The size of the ventricles, or rather the space constituting them, varies. The mucous membrane lining the laryngeal sacs is thickly studded with the openings of numerous follicular glands, situated in the sub-mucous connective tissue. The laryngeal surface of the sac is covered by the inferior portion of the aryteno-epiglottideus muscle (*compressor sacculi laryngis* of Hilton), which compresses it and discharges its secretion upon the true vocal cords, which, being themselves unprovided with glands, are thus lubricated.

The healthy *vocal cords* are easily recognized by their rapid movements during vocalization, and by their striking white, semi-metallic lustre,—at times a mother-of-pearly white in the female. When the two vocal cords are approximated in phonation, the entire breadth of the horizontal surface, forming the floor of the upper laryngeal cavity, is brought to view. The chink or fissure between the free margins of the vocal cords constitutes the *rima glottidis*. Its length varies from ten to thirteen lines, being longer in the male than in the female; in children it is much shorter; and, when fully dilated by a deep inspiration, the space across will vary from six to ten lines. Each cord consists of a compact band of parallel fibres of the thyro-arytenoid muscle, of elastic and fibrous tissue, arranged in prismatic form, the base pointing outwards, so that a vertical section shows the upper surface horizontal, and the lower surface taking an oblique direction downwards and outwards.

The posterior points of insertion of the vocal cords are seen with good illumination as yellowish spots,—the *maculæ flavæ*, which mark the position of the vocal processes of the arytenoids.

When the epiglottis is well erected, as by the emission of a high musical note, so that the anterior parts of the vocal cords can be discerned, we see beneath the small end of the pad of the epiglottis, immediately below the junction of that cartilage to the thyroid, and separating the anterior attachments of the ventricular bands, a well-marked, pinhead-like pit or foramen (*fovea centralis* of Merkel) in the mucous membrane. This fovea centralis communicates directly on both sides with the anterior entrance into each Morgagnian ventricle, being continuous below with a shallow groove formed by a short fold of the laryngeal mucous membrane, which stretches across from the anterior end of one vocal cord to the other. It is very small in the human subject, but quite large in some of the lower animals; in the horse it seems to constitute a middle ventricle to the larynx.

As already mentioned, the form of the rima glottidis varies. During ordinary respiration it is a narrow lozenge-shaped interval, somewhat enlarged and rounded behind. When fully dilated, the rima assumes the form of an isosceles triangle, with the base behind. The form of the rima varies greatly during phonation, and may become elliptical, oval, or only opened anteriorly or posteriorly, as the

cords are contracted in different degrees by the complex laryngeal muscles in the production of the various vocal sounds. In the formation of the head-notes, the arytenoid cartilages are observed to come together, and only the anterior or ligamentous portion of the rima is seen to gape. In the formation of the chest-notes, the entire cord is seen to vibrate; but in the production of the falsetto notes the vibrations of the cord are limited to the free margin of its membranous portion.

The mucous membrane, extending from one arytenoid cartilage to the other, is more or less plicated, and is known as the *commissure* of the arytenoids. It is best examined when the arytenoids are widely separated, and is one of the most frequent sites of ulceration in connection with phthisis.

Below the vocal cords appears the broad yellow cricoid cartilage, and below it again the rings of the trachea are seen elevating the mucous membrane. To obtain an extended view down the trachea, the mirror must be held more perpendicularly, and a deep inspiration made, so as to open the glottis to its fullest extent, and then, by a little manipulation reflecting the light more anteriorly, we are enabled to see the tracheal rings as narrow bands, colored like the conjunctival membrane of the eyelid, arching across with their concavities downwards, becoming narrower and closer as they are more distant, until the foreshortening is such that they cannot be distinctly counted; and sometimes in this way, when the circumstances are favorable, such as a wide glottis, good light, straight trachea, etc., we obtain a view clear down to the bifurcation of the tube.

In examining the trachea, it is a good rule to elevate the position of the patient so that the eye of the observer shall be below the plane of the patient's mouth; then throwing the light from below upon the laryngoscopic mirror, which must be held horizontally, the light can be reflected clear down the tube; and if the bifurcation be visible, we see behind the last ring (below in the mirror), instead of the complete arch with its concavity downwards, a bright triangular ridge, which often seems to project up into the cavity of the tube, and on either side of this bright projecting line dark disks marking the commencement of the bronchi. In a few cases, where the right bronchus is very straight, a ray of light may be so thrown in as to show several of its rings.

STRUCTURES SEEN IN THE RHINOSCOPIC IMAGE.

The most prominent and easily recognized object in the rhinoscopic image (Fig. 6) will be found to be a bright columnar ridge in the middle, gradually expanding upwards. This is formed by the nasal septum, and has in health a pale yellow or almost white color at its lower portion, but as it expands its color gradually merges into the bright red of the mucous membrane of the pharyngeal vault. The lowermost portion of each nasal opening is generally more or less cut off from view by a horizontally-curved projecting ridge, which is formed by the rising up of the posterior surface of the velum; and thus it often becomes impossible to inspect the inferior meatus just beneath the lower turbinated bone. Projecting from the outer wall of the nares on each side, and extending inwards and downwards to within a few lines of the septum, are seen the middle turbinated bones, covered with a gray-

Fig. 6.

THE RHINOSCOPIC IMAGE.

1, septum of the nose; 2, free space of nasal passage; 3, superior meatus; 4, middle meatus; 5, superior turbinated bone; 6, middle do.; 7, inferior do.; 8, pharyngeal outlet of Eustachian tube; 9, upper portion of Rosenmüller's fossa; 10, lateral wall of pharynx; 11, vault of pharynx; 12, posterior surface of velum.

colored mucous membrane: the free end towards the septum, being very wide, lends to the middle turbinated bone a very deceptive resemblance to a polypus. The superior turbinated bone, above the upper meatus, and still within the passage, is seen as a narrow triangular projection of a light pink color.

At the base of the nasal fossæ, the inferior turbinated bones, partially covering the middle ones, are seen as round dark-grayish-looking projections; above them and to the outside will be observed a dark fissure,—the middle meatus.

Upon each side of the lateral walls of the pharynx, on a plane with the inferior turbinated bone, is seen a projecting ridge, which is the cartilaginous extremity of the Eustachian tube; and in it we observe a triangular depression, which is the pharyngeal orifice of that tube. Behind the protuberance caused by the Eustachian tube and the posterior wall of the pharynx is seen a deep canal running upwards and outwards; this is the fossa of Rosenmüller, and is the point in which the Eustachian catheter is so often lodged in ineffectual attempts at its introduction.

The vault of the pharynx must not be neglected in the rhinoscopic examination, since its mucous covering, so abundantly supplied with follicular glands, is very apt to be the starting-point of some diseased condition, such as glandular hypertrophy, ulceration, adenomatous growths, etc.

The parts that can be seen with the rhinoscopic mirror may be enumerated as follows: the posterior surface of the soft palate and uvula; the posterior and part of the lateral portions of the nose, the turbinated bones, and nasal meatuses; the pharyngeal walls of the Eustachian tube and its orifice; the vault of the pharynx and its lateral walls; and the upper portion of the posterior wall of the pharynx. All of these structures cannot, however,

be seen in one and the same image; but by slowly turning the mirror towards the different regions we gradually obtain a satisfactory survey of the whole in detail. Under the most favorable circumstances, both posterior outlets, both Eustachian tubes, and part of the pharyngeal vault, are seen in one and the same image.

ORIGINAL COMMUNICATIONS.

ON THE OPERATION OF "PERINEAL SECTION" FOR URETHRAL STRICTURE.

BY JOHN H. PACKARD, M.D.,
Surgeon to the Episcopal Hospital, Philadelphia.

THE word "impermeable," as applied to strictures of the urethra, although perfectly distinct in its meaning, is in practice an extremely vague term. For, apart from all other circumstances, there is one very variable element in the matter, and that is the skill of the surgeon. A stricture in which Sir Henry Thompson would find no great difficulty, might be absolutely impassable by the same instrument in the hands of a gentleman of less experience and dexterity. Hence the word "impermeable" does not, and cannot, indicate a certain class of strictures, but simply expresses the fact, in regard to any one case, that all attempts at the introduction of instruments into the bladder have failed and are likely to fail.

It is well known that very often a stricture, which seems extremely obstinate, yields at once to the catheter if the patient is placed in a state of anæsthesia.

If in any case the surgeon cannot, with all the means and appliances at his command, and with the aid of ether or chloroform, succeed in reaching the bladder, that stricture is to him impermeable, and, if the symptoms are urgent, some other plan must be resorted to. And the question may well be asked whether it is safer for a surgeon who finds great difficulty in a case, to work on with catheters, and run the risk of doing damage in his efforts to find the channel, or to lay this latter open at once, and give his patient the chance of a new formation of a urethra of full size.

It becomes, therefore, an important point to determine how far the cutting operation from without inwards, in these cases, is attended with risk. I propose to relate presently seven cases of my own, in which the ultimate results were wholly satisfactory. But it must first be stated that authors are not agreed upon this point of the safety of the procedure; and that the distinguished surgeon before mentioned, who is generally recognized as the highest authority on the subject of stricture, makes a marked difference between the "external division" and "perineal section." He speaks as follows in his excellent article in Holmes's "System of Surgery" (vol. iv. p. 974): "Mr. Syme has advocated the division of the stricture for some exceptional cases, in which, *although a catheter can be passed into the bladder*, no other treatment has afforded sufficient or permanent relief. This operation he has called 'external division,' a term which should be reserved for his method; while it is equally desirable to limit the use of the term 'perineal section' to the proceeding just referred to in connection with strictures which have been found impervious to the catheter." In the next paragraph he says, "There is a growing belief, which has greatly influenced practice, that few, if any, strictures exist through which, if the urine issues externally, a catheter of appropriate size may not be passed in the course of time, with care, gentleness, and skill." He endorses this opinion, and says that he has only twice found it necessary to perform "perineal section."

Subsequently (p. 977) he says, "In reference to the operation without a guide, or the perineal section, the best that can be said of it is, that it is a hazardous proceeding, and no surgeon should entertain the idea of performing it except after thoroughly assuring himself that the stricture cannot be rendered permeable to instruments, and so made amenable to other modes of treatment. In a few cases the operation is performed successfully, but in most there can be little doubt that the route of the stricture itself is not followed, and that the knife makes a new channel through adjacent and often very unsound tissues, very inadequate to perform subsequently the function of a urethra. In many instances the attempt to make a channel to the bladder has wholly failed, and the patient has been removed from the operating-table unrelieved; and in not a few the result of the proceeding has been fatal. This termination, however, is to be anticipated in a large proportion of what must necessarily be the worst cases of their kind. Such views of this operation tend to impress us more strongly with the conviction, that every chance of getting an instrument through the dilated urethra by protracted but gentle endeavors, combined with rest and constitutional treatment, should be exhausted before we consent to resort to perineal section."

Prof. Gross, after justly speaking of Syme's procedure as a mere modification of the old button-hole (*boutonnière*) operation, and describing it, says ("System of Surgery," 5th ed., vol. ii. p. 823), "In the button-hole operation, as the conductor is not passed into the bladder, but only down to the seat of the obstruction, the amount of skill required is much greater than in the ordinary procedure. Indeed, it should never be undertaken unless the surgeon is thoroughly acquainted with the anatomy of the parts, is perfectly self-possessed, and knows how to use the knife. A number of cases have been reported in which death occurred from hemorrhage, shock, pyæmia, erysipelas, or urinary infiltration."

Sir William Fergusson ("System of Practical Surgery," 5th ed., p. 693) says, "In some instances there is such an amount of local disease and continued irritation that life is hardly worth enduring: in other cases speedy death is impending unless the surgeon interferes, and if he cuts into the perineum in the mesial line, divides the stricture and introduces a full-sized catheter along the whole of the urethra into the bladder, he is resorting to an old established practice of surgery which

can scarcely be sufficiently praised. It confers the greatest relief on the patient, and may justly be called a triumph of surgery. It is a formidable operation, however, and as such is not free from danger. Death sometimes follows, and hence the surgeon is cautious in resorting to it, excepting in extremity."

Other authorities might be cited, but perhaps it is hardly necessary. I believe that the continental writers, the French certainly, are but little in favor of the "perineal section."

One other alternative has been by some authors highly praised for the relief of the condition in question, viz., tapping by the rectum. Mr. Oliver Pemberton, in a recent address before the British Medical Association, advocates this procedure quite warmly. (And here we note another of those unavoidable uncertainties of expression, which may well puzzle a young and inexperienced man. "If," says Mr. Pemberton, "the induration of the urethra, and narrowing, be of such an extent as to preclude the idea of dealing with it by external division, I prefer to tap the bladder by the rectum." How is a man to decide what "such an extent" is, if he has never had practical, and especially hospital, experience in cases of this kind?) Tapping of the bladder through the rectum has never been an operation in much favor in this country; I have never known of its performance in this city.

I propose now to relate my own cases, which are taken from the records of my hospital service, and which seem to me to sustain, so far as they go, the value of the operation of "perineal section." One of them is particularly interesting, since the physiological rest, given to the urethra by the incision, made catheterization, impossible at the time, very easy three weeks afterwards.

Case I.—C. H., a colored coachman, came under my care in July, 1861, suffering from complete retention of urine, due to an old stricture,—not, I believe, of venereal origin. After satisfying myself that I could not introduce any instrument, I sent him to the Pennsylvania Hospital, where "perineal section" was performed by Dr. Hewson. By this operation he obtained temporary relief, but the symptoms all returned, the retention was relieved by the bursting of urinary abscesses, and he finally was admitted under my care at the Episcopal Hospital, in 1865, suffering with stricture, fistulæ of great extent, and difficulty of urination. I divided the stricture by perineal section, and laid open the shorter fistulæ, cauterizing the latter with a hot iron, and passed oakum setons through the longer fistulæ. Healing took place without contraction, by means of the steady use of large instruments; all the fistulæ closed, and he has now been for about seven years wholly free from stricture or any difficulty in urination, notwithstanding the fact that he has of late neglected the use of the bougie.

Case II.—August 4, 1867, I operated on a sailor at the Episcopal Hospital, whose stricture would not yield to any efforts at catheterization on my part. On dividing the tissues in the median line, I was fortunate enough to hit the urethra beyond the narrowed portion, which was freely laid open. The case did well, and the man was discharged entirely relieved. (The exact time of treatment in this, as in most of the other cases, I cannot easily ascertain.) Of course I have lost sight of him since, as is apt to be the case with sailors.

Case III.—R. D., æt. 30, was the subject of a traumatic stricture of seven years' standing, caused by a bank of clay caving in on him and fracturing the pelvis. I performed "perineal section" on him on the 26th of October, 1868, at the Episcopal Hospital. With very great difficulty, a grooved director was inserted into the bladder from the wound, and tied in. On the 31st I succeeded in slipping a small silver catheter along the urethra, and, guided by the director, into the bladder.

November 2, a large-sized double-curved instrument was passed, and tied in.

December 11, the urine is noted to have been passed almost wholly through the catheter for a week.

January 17, 1869, the instrument was removed. Two fistulæ existed, one at the seat of operation, and one at the root of the scrotum, caused by the angulation of the tissues by pressure of the catheter. The former healed spontaneously. The other one was twice sutured, and repeatedly cauterized; it finally closed to a mere pinhole, and he was discharged May 4, passing his urine in a full stream. Two years later he wrote me from the interior of the State that he was quite well, and had married.

Case IV.—C. R., æt. 35, was operated on by me at the Episcopal Hospital, October 12, 1869, for an impassable stricture, by "perineal section." He did well, and was discharged with a urethra of normal calibre.

Case V.—September 30, 1870, I operated on J. L., æt. about 35, at the Episcopal Hospital, for traumatic stricture of several years' standing. After many attempts, I failed to get any instrument into the bladder. The urine came away wholly by the wound. About *three weeks afterwards*, I succeeded in passing a silver catheter of small size along the urethra into the bladder, and left it in place. Larger instruments were afterwards passed, and he was discharged cured.

Case VI.—December 21, 1871, I operated on a man at the Episcopal Hospital, William ——, æt. 30, by "perineal section," for the relief of stricture with fistula. He did perfectly well, and is now employed as an assistant in the house.

Case VII.—A. W., æt. 39, slipped and fell on his belly two years ago. About a week afterwards he had trouble in urinating, and was relieved by means of a catheter. He has never since then been able to pass water freely. An abscess formed some three months later, and others have been forming about every three months since that time. He passes about a teacupful daily through the natural channel; the rest dribbles away through numerous fistulæ in the scrotum and perineum.

December 5, 1872, I performed "perineal section," and after much difficulty got a grooved director from the wound into the bladder, and then a small silver catheter the whole length of the urethra.

December 9.—The catheter was removed and cleaned. From this time until the 31st, the removal and cleansing was done daily; and on the 12th of January, 1873, he was discharged entirely cured, with directions to attend to keeping the urethra dilated.

The above cases are only those which have occurred to myself. I have seen a number of others, some sixteen in all, operated on by other surgeons, with good results. Let me not be understood to maintain that this procedure is one to be lightly undertaken, or free from risk; but I think the favorable experience of it in my own hands, as now recorded, may be allowed some weight. The cases requiring it are certainly among the most urgent which come under surgical care.

1928 SPRUCE STREET, Feb. 1873.

NOTES OF HOSPITAL PRACTICE.

JEFFERSON MEDICAL COLLEGE.

SURGICAL CLINIC OF PROF. S. D. GROSS.

Reported by FRANK WOODBURY.

AMPUTATION OF PART OF THE TONGUE FOR CARCINOMATOUS DISEASE.

UPON looking at this patient (thirty-eight years of age) you see at a glance that he is a sick man; his face is sallow, and his frame is emaciated. He states that since he first began to be sick, nine months ago, he has lost over forty pounds in weight. The quantity of urine voided is normal in quantity and quality. His bowels are open; he has no flatulence, indigestion, nor unusual thirst; his appetite is good, but he cannot eat; his hands and feet are warm; he never had intermittent fever, or night-sweats, but he has a trouble of his tongue, which commenced four weeks ago, in which he experiences constant burning, at times lancinating, pain, which seriously interferes with mastication and deglutition. As he protrudes the tongue, you notice a surface continuously ulcerated, principally on the left side of the median line, extending from the tip a considerable distance back. I can find no enlarged lymphatic glands under the jaw. His diet is necessarily confined to the blandest articles, and such as require no mastication, such as milk, beef-tea, and milk-punch. His face is not pallid or livid exactly, but has a sallow, cadaverous appearance peculiar to the cancerous cachexia.

This may be either of two affections,—syphilis or epithelioma. A man may have a chancre on his lip or tongue by inoculation from a mucous patch, or directly from virus accidentally carried by the finger; or an ulcer may exist here as the result of constitutional syphilis. In such a case, however, the ulcers have well-defined edges, generally with a foul, irregular base, and are not single, but appear in scattered patches; they are not confined to the tongue usually, but co-exist on the fauces, uvula, and pharynx. There would also be evidences of specific disease in other portions of the body, and a distinct history of inoculation, neither of which exists in the present case.

Therefore, by exclusion, and from the appearance, hardness, and peculiar pain, I would consider this epithelial cancer, or cancroid, as it was termed by Prof. Miller, of Edinburgh; or, properly, scirrhus modified by the structure involved. This generally comes without assignable cause. It has been attributed to smoking a short pipe, with the hot stem constantly against the tongue; but this is unsustainable by proof, the disease in some cases occurring in patients who never smoked, while thousands of others escape who are inveterate smokers. Encephaloid disease of the tongue is extremely rare, while colloid and melanosis in this situation are unknown. This disease is most common after the age of fifty, and in the male sex. It commences as a little sore, papule, or crevice, in the tongue; it then gradually spreads and ulcerates, and is the seat of the characteristic pain, which is generally worse at night. The surrounding part is hard, from infiltration of plastic lymph and cancer-cells, and the organ can no longer be used in mastication, on account of its stiffness and the pain produced by moving it. The disease finally extends to the gums, the teeth fall out, the submaxillary glands enlarge, and the system sinks under the exhaustion from the cachexia which becomes established, and from impaired nutrition. The fatal result generally supervenes within a year or eighteen months from the onset of the disease.

The only operation likely to afford any relief would be excision of the affected part, not in the hope of cure, but to palliate the symptoms. But he is not in a condition to bear such interference at present; his general health must first be improved by relieving his pain and allowing him to sleep, by giving him gr. xxx of chloral at night. He shall have plenty of soft, nourishing food, such as milk-punch, animal broths, soft-boiled eggs, etc., with daily open-air exercise, and may wash his mouth frequently with dilute solution of permanganate of potassa. It is important that the patient should not swallow the secretions, as pyæmia might result. I have seen this occur in two cases,—in one after removal of a polypus, and in the other from plugging the posterior nares.

November 20 (one month later).—The patient's health is much improved, and he returns for operation. The ulcer is now rapidly spreading beyond the median line of the tongue, and also on the under surface. Ablation, or excision of the tongue, is not required in this case; removal of the offending part is all that will be attempted. This should not be done with the knife, as there would be severe, perhaps uncontrollable, hemorrhage from the vessels, which are now abnormally increased by the disease. This is one of the operations to which the écraseur is eminently applicable, as it crushes and lacerates the vessels, producing rapid coagulation of the blood and diminishing hemorrhage. Before applying the chain of the instrument, the tongue is transfixed by three stout steel pins at the line where you wish to amputate. The écraseur is then applied and the diseased mass removed. The lingual artery and a few small vessels required the ligature; the capillary oozing was checked by ice. The operation was performed without an anæsthetic, at the patient's request. An anodyne will be given immediately, and the former treatment continued, to which shall be added quinine and iron.

[The patient was subsequently shown at the clinic, and reported himself as being much more comfortable. He made a good recovery from the operation, and there was no secondary hemorrhage. He was then able to speak so as to be understood, although half of the anterior portion of the tongue had been removed transversely. He afterwards complained of a severe sore throat, and within two months from the operation died from debility. No examination could be obtained.]

IMMENSE NÆVUS ON SCALP.

This child (nine months old) is brought before you to exhibit the progress of a nævus maternus without operative interference. This disease, although undoubtedly of congenital origin, yet was then so small that it was not noticed until several weeks after birth. It was then on the scalp, but gradually spread, so that it now extends over the top of the head towards the right side, and involves the entire left side of the scalp, forehead, face, and neck, distorting the ear and almost closing the eye. The tumor is soft, bluish, pulsates, and is apparently painless.

This is the type of a nævoid tumor. It is composed essentially of dilated capillaries, which are abnormally numerous, having a cavernous structure in parts, resembling the erectile tissue of the corpora cavernosa or the spleen. These tumors vary according as the arterial or the venous element predominates in them: where they are both equally represented, it forms the true aneurism by anastomosis of Mr. Bell. Where the venous element is in excess, there is not such great danger of hemorrhage, and the tumor may be removed by the knife, or the spongy structure torn out by the forceps, as has been recommended by my colleague, Prof. Pancoast.* When the arterial character of the

* *Medical Times*, vol. i. p. 288.

tumor is more marked, as is seen by the scarlet color and decided pulsation, then the risk of hemorrhage would be far greater, and strangulation by the ligature would be the safest operation. Other means of treatment have been recommended, as by injecting styptics, but they are uncertain and dangerous. Some surgeons have cured them, when small, by vaccinating over them. Setons, either simple or impregnated with Monsel's solution, have been used effectively; and large tumors may be obliterated by darning them with these threads, which excite inflammation and plastic effusion, thus occluding the vessels.

The disease here is rapidly spreading, and, if not stopped, will soon involve the entire head and shoulder. I would suggest that the largest portion of the tumor be strangulated by the pins and a stout ligature, and the remaining portion be left for a subsequent operation. By undertaking too much at once, we might increase the danger from pyæmia or erysipelas.

If this child were older, or the disease had existed for a long time, we would undoubtedly find in it phleboliths, formed from plasma which had undergone the earthy degeneration.

TRANSLATIONS.

VON OPPOLZER'S LECTURES ON DISEASES OF THE ŒSOPHAGUS.

Being the latter portion of the first part of the second volume of Oppolzer's Vorlesungen über specielle Pathologie und Therapie, Erlangen, 1872.

Condensed from the German of Dr. Emil Ritter von Stoffella,

BY DR. J. SOLIS COHEN.

II.

ŒSOPHAGITIS.

INFLAMMATION of the œsophagus is either catarrhal, croupal, or pustular. It may extend over a large portion of the œsophagus, or be confined to a small portion. It occurs as an idiopathic affection less frequently than as consecutive to some other affection. Besides these three designated forms of inflammation, there is that of ulceration; and, in poisoning with caustic substances, more or less extensive gangrene of the œsophageal mucous membrane.

Acute catarrhal œsophagitis may result, idiopathically, from change of temperature; from the deglutition of very hot or very cold viands, or of irritating or caustic substances, as in moderate degrees of poisoning; from the mechanical irritation of sharp impacted bodies, as bits of bone, etc. It may occur consecutively by extension of gastric catarrh, or catarrh of the mouth and pharynx. It may occur symptomatically in the acute exanthemata, especially in measles and typhus fever.

Chronic catarrhal œsophagitis may follow acute inflammation of the mucous membrane; or it may follow some long-continued or frequently renewed irritation of the œsophageal mucous membrane; or it may follow habitual stasis of the blood in the veins of the œsophagus. It is encountered particularly in inveterate tobacco-smokers, in individuals who indulge immoderately in alcoholic beverages, and in those suffering with some chronic pulmonary or cardiac disease. Syphilis, too, seems to favor the occurrence of a chronic catarrhal affection of the œsophageal mucous membrane.

Croupal inflammation of the œsophageal mucous membrane is a much rarer affection than catarrhal inflammation. Œsophageal croup exists in combination with croup of the pharynx or larynx, or, in certain cases, in connection with croupal pneumonia. It is also encountered in typhus fever, in the third or fourth week of the disease; in the acute exanthems, especially in smallpox and scarlatina; in cholera; in pyæmia; often, also, in dysentery; and, finally, in tuberculosis and carcinoma.

Pustulous inflammation of the œsophageal mucous membrane occurs principally in the wake of the use of tartarized antimony; or else as one of the phenomena of variola. It is an exceedingly infrequent affection.

Ulcers of the œsophageal mucous membrane result either from the above-enumerated forms of inflammation, especially catarrh, or from traumatic injury, scalding, or the action of corrosive substances. Tuberculous ulcers are encountered very seldom, only; but cancerous ulcers are met with much more frequently.

The symptoms of inflammatory affections of the œsophagus are usually obscure. This is, in part, to be accounted for by the comparative insensitiveness of the organ. Chronic inflammations sometimes pursue their course without giving rise to a single characteristic symptom. Acute inflammations of moderate intensity, or of circumscribed extent, very often occasion only a dull pain beneath the sternum, a feeling of constriction, or a slight impediment to deglutition, and the discharge of a more or less viscid mucus. Vomiting seldom occurs in these cases, and usually only when the pharynx is over-irritated by the accumulations of viscid mucus. Even when the inflammation is severe, the symptoms are often so masked by the symptoms of some co-existing affection, as to divert the physician's attention from the condition of the œsophagus itself. Thus, croup of the œsophagus, which appears in the course of severe scarlatina or typhus, or in connection with croup of the larynx, is in most cases altogether latent.

In those cases, however, in which the inflammation of the œsophagus is idiopathic and acute, and of a certain extent and intensity; and also, it is not to be denied, in a large proportion of cases of secondary catarrhal or croupous inflammation, we find symptoms so characteristic that the disease of the œsophagus cannot be overlooked; and in most instances these symptoms indicate the correct diagnosis. The patients complain of a more or less severe pain in the course of the œsophagus, usually most painful beneath the manubrium sterni or in the pit of the stomach; less frequently between the shoulder-blades. This pain is increased by swallowing, especially of solids, and also by pressure from the outside, if the seat of disease be in the upper portion of the œsophagus. If the inflammation is sufficiently intense, the swelling of the mucous membrane may be so great as to constrict the calibre of the œsophagus to such an extent as to render deglutition not only difficult, but even impossible in marked cases; and repeated attempts to swallow will end in regurgitation, or even provoke vomiting, with the discharge of ingesta, as the case may be, and a greater or less admixture of sanguinolent mucus. Not infrequently a spasm of the œsophagus ensues on deglutition, and in most instances involves the respiratory organs, so that there is a sense of impending suffocation with intense dyspnœa.

It may be remarked, in passing, that it is not so much the swelling of the mucous membrane that impedes deglutition or renders it impossible, as the co-existent inflammation of the muscles, or, at least, their serous infiltration, which impairs their ability to grasp the bolus and propel it farther. The patient exhibits continual anxiety, and constantly complains of a great compression in the chest. Febrile phenomena supervene if the inflammation involves a large extent of surface, and, in isolated cases, may terminate in convulsions.

In the croupous inflammation, it often happens, in addition to the above-enumerated symptoms, that shreds of false membrane are hawked up or vomited,

as in the cases reported by Abercrombie, Winslow, J. Frank, Hennig, and others.

The termination of œsophagitis, if simply catarrhal and acute, is in recovery in a few days, or in chronic catarrh of the œsophagus. Pustulous inflammation following the use of tartarized antimony also terminates, usually, in recovery. Not so, however, where the pustulous inflammation is a manifestation of small-pox, or where croupous inflammation exists. Cases of these varieties usually terminate fatally. Cases of simple inflammation, but intense in character, involving not only the mucous membrane but the subjacent connective tissue also, and denominated "phlegmonous œsophagitis," sometimes terminate fatally within two or three days; or, if this period is passed, at a later date, from the partial or complete adherence of the walls of the œsophagus: in other cases abscesses form, which discharge internally, or externally, and leave a condition of stricture.

The treatment of acute œsophagitis does not require any special therapeutic measures, as a rule. If the inflammation is severe, the parts must be protected against further irritation, and efforts be made to allay that already existing. To this end the patient is forbidden to speak much, or to make much effort in swallowing. Fluid nutriment is given, and demulcent drinks are administered; the latter containing anodynes if required. Thirst is allayed by bits of ice allowed to melt in the mouth, by the sucking of orange-juice, or by rinsing the mouth frequently with acidulated water. Local depletion near the seat of pain is indicated only in cases where the pain is rather high up, and in which relief has not followed the external application of cold, or the subcutaneous injection of narcotics.

The cause of the œsophagitis, when discoverable, must be attended to. Foreign bodies must be extracted. Deglutition of concentrated acids must be treated by the administration of alkaline drinks. Caustic alkalies must be followed by acid drinks; the best of which, according to Orfila's experience, is a mixture of vinegar and water.

The treatment of chronic œsophagitis will depend greatly on the cause of the disease. Syphilitic inflammation is to be handled with antisyphilitic remedies. Disturbances of circulation require the use of digitalis, and of dilute mineral waters. The diet must be attended to; alcohol, and food of all kinds that is liable to produce irritation chemically or mechanically, must be interdicted, or used under certain restrictions commensurate with the degree of dysphagia and the irritability of the œsophageal mucous membrane.

Local treatment is called for, and consists usually in swabbing the diseased tissues with solutions of tannin, alum, iodine, or nitrate of silver; the article last named occupying the chief *rôle* in this connection. It is also recommended to cauterize the painful surface superficially with a weak solution of nitrate of silver as soon as there is reason to fear that the pain is due to the process of ulceration. In addition to this, counter-irritants are applied to the back of the neck, to the region over the dorsal vertebræ; steam-baths and warm plunge-baths are resorted to; and drinks of carbonic acid waters administered. The internal use of iodide of potassium has often been advantageous, especially in cases of circumscribed extent. If stenosis ensue as a result of chronic œsophagitis, it requires special surgical treatment.

After a patient has been relieved of an œsophagitis, even when only moderately intense, the physician should not neglect to advise occasional catheterization of the œsophagus for a period of at least two years; in order to avoid stenosis, on the one hand, or to detect it early, on the other.

MYCOSIS SEPTICA IN A NEW-BORN CHILD (Orth: quoted from *Centralblatt für Med. Wiss.*, No. 41, 1872).—At the post-mortem examination, three days and a half after birth, the author found in the right pleural cavity a large amount of flocculo-purulent exudation, which was in connection with an abscess as large as a cherry-stone, situated on the under edge of the inferior lobe of the lung. The superior lobe of the left lung contained a similar abscess of small size. An examination, thirty hours after death, of the fibrino-purulent matter found upon the surface of the right lung, showed that it consisted of masses composed of small, shining granules and pus-cells.

These collections, or colonies, as well as similar bodies on the pleural surface, were found to contain countless micrococci and small round cells. The abscesses in the lungs contained ordinary pus-cells, without any admixture of fungous elements. The entire parenchyma, however, as well as the cavity of the alveoli, bronchi, and vessels of the rest of the lung, were filled with a countless mass of these same fungi, with a slight admixture of white and red blood-cells. The kidneys and all the other organs were free from these bodies. The mucous membrane of the bladder, however, and the blood revealed the presence of these fungi. The umbilical cord and its vessels were intact. Although the examination was made so long after death, the existence of cold weather inclines the author to think that the presence of the micrococci dates from intra-uterine life, since the mother, before the birth of the child, had severe fever and suffered from a severe perimetritis. The author supposes that the fungi escaped from the blood of the mother into that of the child. Ponfick, in a notice of the case, says that the subsequent dissemination of these bodies through the organism of the child must be regarded as emanating from the abscess in the lung, for the filling of the pleural cavity, as above described, could not have arisen from the circulation, but from the abscesses in the lung.

A CASE OF RUPTURE OF THE UTERUS AND ESCAPE OF THE FŒTUS WITH ITS APPENDAGES INTO THE PERITONEAL CAVITY—ABDOMINAL SECTION—CURE (Fourrier: *Bull. Général de Thérapeutique*, tome lxxxiii. liv. 3: quoted from *Centralblatt für Med. Wiss.*, No. 43, 1872).—This accident happened to a woman in her third pregnancy, who had a severe fall six weeks before the termination of gestation, and to whom, before the os had dilated, two grains of ergotine were given by an inexperienced midwife. The occurrence of the rupture was instantly felt; the diagnosis was rendered unmistakable by the presence of two tumors, which were readily recognized as the uterus and the fœtus. The symptoms were very grave, but were not those of general peritonitis. Fourrier made an incision fourteen inches long over the fœtus, on the outer side of the right rectus abdominis, came instantly upon the dead child, and, without any manipulations of the intestines, successfully performed detruncation. He was also able, without altering the surroundings, to remove the fœtus with all its appendages. The gangrenous shreds of peritoneum and clots of blood which filled the cavity were carefully removed, and the wound was partially closed by three sutures.

Convalescence occurred in sixty-two days. At first, disinfection and removal of the sloughing tissues were sources of care; later, a slight phlegmasia and a pyæmiform fever created some alarm. Obstinate constipation was a chief symptom for some time. At the time of publication of these notes the menstrual period had not returned, the uterus was somewhat enlarged, not completely immovable, and greatly inclined towards the left side.

PHILADELPHIA
MEDICAL TIMES.
A WEEKLY JOURNAL OF
MEDICAL AND SURGICAL SCIENCE.

The Philadelphia Medical Times is an independent journal, devoted to no ends or interests whatever but those common to all who cultivate the science of medicine. Its columns are open to all those who wish to express their views on any subject coming within its legitimate sphere.

We invite contributions, reports of cases, notes and queries, medical news, and whatever may tend to increase the value of our pages.

All communications must bear the name of the sender (whether the name is to be published or not), and should be addressed to Editor Philadelphia Medical Times, care of the Publishers.

PUBLISHED EVERY SATURDAY BY
J. B. LIPPINCOTT & CO.,
715 and 717 Market St., Philadelphia, and 25 Bond St., New York.

SATURDAY, FEBRUARY 8, 1873.

EDITORIAL.

WE are happy to announce that by an arrangement entered into with a gentleman in London, of high professional standing and well-known literary ability, we shall hereafter lay before our readers, every other week, a letter containing the cream of the professional and scientific news and gossip of that city.

THE "STEERAGE."

ATTENTION has many times been called, with more or less effect, to the abuses which exist on board of emigrant-vessels; and much legislation has been directed to the most desirable end of their correction. Personal observation has shown us that there is a real foundation for complaint, even on the best-managed lines; we can never forget some of the scenes we have witnessed in the "steerage." A great deal of the trouble is fairly to be charged to the low character of the persons who take passage in this way; but by no means can the whole blame be shifted from the owners and managers of the lines.

Our attention has recently been called to this matter by some excellent remarks in the *Public Ledger*, in reference to a published letter describing one of the late voyages of the steamer "Erin," of the London and New York line. The account, as condensed in that paper, speaks for itself better than any amount of generalizing on the subject could do; and we therefore transcribe it:

"The recent developments which lead to these remarks are contained in a letter published by Mr. J. P. McDonnell, of New York, who has just made a voyage from London, via Havre, to New York, in the steamship 'Erin.' His letter is published over his own name; it is entirely dispassionate in its tone; it states the facts without abuse, and even speaks words of personal kindness towards the principal officers of the ship. It is to the still existing scandalous abuses of the 'steerage,' as exemplified on board this particular ship, that he invites attention. The 'Erin' sailed from London for Havre, on her way to New York, at four o'clock, Thursday morning, December 5th. Her sailing-day was the preceding Saturday, November 30th. During these five days her London 'steerage' passengers, among whom were thirty women and children, were detained 'shivering in the cold in the disgustingly filthy Victoria Docks.' This in itself was a gross wrong; but, considering what came afterwards, it was a trifle. At Havre about eight hundred more passengers were taken on, making about eight hundred and fifty in all, and these, with the ship's company, made a total of about a thousand souls on board. There were not 'accommodations' on the ship for this number of people, and at Havre 'bunks' were hurriedly constructed for about three hundred on the 'main deck.' Some of these 'bunks' contained seven or eight persons—men, women, and children—in a space where, by right, there should have been only two persons. Before the close of the voyage, even these wretched 'accommodations' for the 'steerage' passengers were taken from them, and they were all—men, women, and children—stowed away on the 'damp and loose planks of the midships,' which had been used down to this time for the storage of coal, and from which the coal had been taken out to supply the boilers of the steamer during the voyage! After they had been thus stowed away in this 'coal-hole,' Mr. McDonnell says it 'looked like a huge sepulchre.' An American officer, who passed through our recent war, said that 'he never, during his entire career, witnessed a sight so truly pitiable.'

"The picture thus exhibited is by no means the worst in Mr. McDonnell's narrative, the details of some others being of a character that can only be presented by saying the 'accommodations' of the ship were disgusting to the senses, revolting to decency, and could not have failed to be detrimental to health. We pass now to some other matters in the letter. For the thousand souls on board there were but two doctors. Six persons died during the voyage, and one of these could get no medical treatment until the day he died. For all the 'steerage' women and children there was but one stewardess, and at the outset of the voyage there were but three regular stewards for all the rest of the passengers. The result of this was that, in serving out the food, the strong got 'more than their allowance, the weak got none at all.' By the contract, each passenger was entitled to two quarts of water, 'but found it difficult to get even one pint.' The potatoes furnished 'were black and soft as wet soap;' the meat was so

hard and bad that the 'most famished-looking refused to take it,' and the tea and coffee were 'disgustingly nauseous.' The ship itself was in bad condition; her decks were leaky, and the water rained down on the 'steerage;' her midships were not strong; and she leaked to the extent of 'from six to nine feet of water a day,' which the pumps had to discharge. The passengers were promised a sixteen-day voyage, and got in place of it a twenty-eight days' experience of these 'steerage accommodations,' during which the women and children had at no time any protection by means of screens, partitions, closets, or other privacies, which would have enabled them to observe the commonest decencies of life.

"This condensed recital gives but an inadequate idea of the condition of the 'steerage' aboard the steamship 'Erin,' as described by Mr. McDonnell, and it is sufficient to show, either that the laws are not executed, or that some additional chapters are needed to the voluminous legislation about passenger 'vessels propelled in whole or in part by steam.'"

We would be far from depreciating the efforts of the religious world for the reclamation of the heathen; but we would venture to suggest that, while "man's inhumanity to man" finds such illustration as this in the dealings of "Christian" owners of vessels with the unprotected emigrant, there is a field very near home which has not yet been brought to the highest pitch of cultivation. It would seem also as if the societies which advocate "warming the bits before putting them in the horses' mouths," and whose members have such pity for galled and lame animals, might pause a moment to think whether there are not nobler, higher, and more urgent claimants of their sympathies and their benevolent interposition.

NEW JOURNALS.

WE have upon our table two new medical periodicals,—one American, the other Irish.

The American is the *Archives of Scientific and Practical Medicine*, edited by Drs. Brown-Séquard and Seguin. Its typography is worthy of its valuable and interesting contents. The leading article —a report of a case of traumatic brachial neuralgia, treated by excision of the cords which go to form the brachial plexus, by Drs. Sands and Seguin—is illustrated by a very handsome lithographic plate. Among the other papers we note one by "Dr. Mary C. Putnam" on "the significance of the pulse in the forming stage of generalized puerperal peritonitis." Ability and judgment have evidently been exercised in the preparation of the translations, reviews, and summaries.

The *Irish Hospital Gazette* is intended to take "the place left vacant by the *Dublin Hospital Gazette*, the change of title being adopted to mark it specially as the organ of the profession at large throughout Ireland." The first number contains much excellent reading-matter and several woodcuts; the second is promised for the 15th of January, but we have not yet received it. We presume the subsequent issues are to be fortnightly.

CORRESPONDENCE.

MEDICAL TRAINING.

To the Editor of the Philadelphia Medical Times:

THERE is a notion in the mind of the medical public that, in spite of their continuous efforts to improve it, the system of education followed in the medical schools is still defective,—that a large portion of the numbers of gentlemen who graduate every year are not yet fairly qualified to practise medicine in any of its departments advantageously to their patients. Even among those whose natural endowments and scholastic acquirements are sufficient, there are many who, immediately after graduation, are incompetent to apply at the bedside what they have learned in the schools. Professional lectures carefully heard and text-books attentively read enable intelligent students to acquire knowledge of the principles and theories upon which the practice of the healing art depends. The average pupils of the medical schools of the day listen to the professors and read the text-books, not with a view to immediate professional practice, but to pass examinations. It is the fashion to regard this as paramount to every other consideration. To prepare for examination, to learn in a limited period of time to answer all questions that examiners are likely to ask, seems to be the chief object of all effort. In connection with the schools there are private lecturers or companies of lecturers, some of whom announce that their special business is to qualify candidates to pass certain examinations. Pupils who patronize them have their memories crammed full of answers to the probable and possible questions of the prospective examiners, only to be forgotten within a few weeks after passing the examinations for which they have been thus prepared.

Some of those who avail themselves of this kind of assistance perceive that if they make themselves masters of the subjects taught, they must necessarily be able to pass examinations upon them. Those who study for the sole purpose of acquiring knowledge with comparatively little thought about passing examinations, enter hospitals, and, being trained in them, become reliable practitioners, and ultimately distinguished members of the profession. In hospitals they learn that the successful practice of medicine consists largely in personal service to individuals, requiring manipulations of various kinds at almost every step,—manipulations

which must be often repeated before they can be skilfully executed.

The student resident in a hospital very soon finds that he was not taught in his school what to observe or how to note his observations or to report them, and that his hands are without instruction in the use of instruments of any kind. In a word, he finds that he was educated at the medical school, but not trained in any degree to apply his knowledge efficiently in relieving sick or wounded persons. He may have often witnessed at the clinics operations of frequent necessity performed so skilfully and readily that they seemed to him so easy of execution that any tyro might repeat them equally well. And yet, when called upon the first time to introduce a catheter, for instance, he is surprised at his want of success in doing what he has often seen done without any apparent difficulty. Indeed, even the well-educated graduate is not unfrequently at a loss when he first assumes the responsibility of treating a serious case of disease, through want of that kind of knowledge which is acquired in hospital training or in practice.

With a view to obviate the kind of deficiency alluded to, the British government has established, at the military hospital at Netley, a school for training newly-appointed assistant-surgeons of the army and navy in the details and routine of professional and official duties.

The present organization is as follows: Deputy Inspector-General T. Longmore, Professor of Military Surgery.

Deputy Inspector-General W. C. Maclean, M.D., Professor of Military Medicine.

E. A. Parkes, M.D., Professor of Military Hygiene.

W. Aitken, M.D., Professor of Pathology.

Staff-Surgeon John Dennis Macdonald, M.D., Professor of Naval Hygiene; and four assistant professors selected from the medical staff of the army.

As with us, candidates for admission into the medical staff of the army or navy submit to a competitive examination. Those who are successful are sent to Netley on probation for four or six months.

The candidate commences his career in the wards of the hospital under the supervision of the staff surgeon of the division. He is held responsible for the ventilation and general neatness of the ward, as well as for the keeping of the different books and papers. He is required to keep a case-book, which is examined at the end of the course, and marked according to professional and literary merit, attention to detail of regulations, neatness, etc.

Each candidate is supplied with a microscope and other necessary instruments for his exclusive use, for which he is held responsible. He has a closet for their preservation. He is exercised in microscopic examination of tissues and morbid specimens in the microscope room, and he is made practically familiar with processes followed in the analysis of air, drinking-water, food, soils, etc., in the laboratory. He has also the use of libraries, museums, etc. designed to aid him in his studies.

A detailed account of this school is given in a report to the Surgeon-General of the U.S. Navy, by Medical Inspector Edward Shippen, U.S. Navy, Fleet-Surgeon on the European station.

Surgeon-General James C. Palmer, U.S. Navy, in his annual report to the Secretary of the Navy, suggests that a similar school be established for training assistant-surgeons of the Navy of the United States, and, to enable him to commence it, asks an appropriation of $15,000, a moderate sum for a purpose so valuable.

The commencement of such an institution is desirable. Though a very long time may elapse before it may be compared in any respect with the school at Netley, it cannot fail to exert a very beneficial influence on the naval medical service of the United States, and thus indirectly contribute to the general efficiency of the navy. R.

MEDICAL OFFICERS FOR THE AMERICAN STEAMSHIP COMPANY.

To the Editor of the Philadelphia Medical Times:

AS the time draws near for the completion of the vessels of this Company, the question of the selection of properly qualified medical officers presents itself to the Board of Directors. As to the importance of this question to the travelling public there can be no doubt in the minds of medical men. Whether the Board feels the responsibility imposed upon them in this respect is not so certain. Whilst they are exercising the greatest care in the selection of the captains, engineers, and other important executive officers, it is believed that those persons who can command the greatest personal influence will be appointed to the positions of surgeons. If this is correct, then the professional qualifications of the candidates become a secondary consideration.

I take the liberty of suggesting to the Board the propriety of submitting the candidates for the positions as surgeons to an examination, to be conducted by a Board of Examiners selected from the medical teachers of our city. Let the gentlemen who are to compose this Board be named by the Deans of the University and Jefferson Medical College.

The examination should be largely practical in character, and no candidate should be examined who has not had at least three years of experience in the practice of medicine and surgery.

In this way the Company will secure the services of competent medical officers, and the public will feel that at least one danger is removed in their travels upon the sea. M.

WARM.

Editor Philadelphia Medical Times:

DEAR SIR:—I have received another note from my friend Simkins. On this occasion it was called forth by a very serious illness from which I suffered, caused, I have no doubt, by overwork during

the intense heat of last summer in taking care of my friend Simkins's patients:

"My dear Timkins:

"I have just heard of your serious illness. In view of the fact that the uncertainties of life are great, and that the position you now hold in —— Hospital *may* become vacant, I have thought it advisable to commence an active canvass for it. I write to ask as a favor (possibly your last) that you will send me a letter of introduction to the President of the Board of Trustees. You can also send such testimonials as you may think proper. If I secure your place, it will be my nineteenth.

"Yours, very affectionately,

"Simkins."

Whereas, Mr. Editor, I was cool towards my friend Simkins, I now entertain for him a warm affection.

Yours, respectfully,

Timkins.

PROCEEDINGS OF SOCIETIES.

PATHOLOGICAL SOCIETY OF PHILADELPHIA.

Thursday, January 9, 1873.

The President, Dr. J. H. Hutchinson, in the chair.

Dr. WILLIAM F. NORRIS presented the following specimens:

I. *Glioma of the retina, with numerous metastases.*

B. N., æt. two and a half years, was brought by his parents to the clinic of the University of Pennsylvania in October, 1870, with the statement that in the winter previous they had noticed a yellowish reflex from the right pupil. The right eye was slightly prominent, lid a little swollen but not reddened, the eyeball very tense (T_2), commencing opacities in the cornea, a small quantity of pus in the anterior chamber, the lens yellowish and so far opaque that nothing could be seen behind it.

The case having been recognized as one of glioma, enucleation of the eyeball was performed October 20, 1870. The wound healed rapidly, and in ten days the child returned to his home.

The eyeball was laid in Müller's fluid to harden, and, when a section was made of it, a tumor was seen filling the posterior half of the ball, the anterior portion being filled with pus. To the outer upper side of the ball was a tumor firmly adhering to the sclera, shaped as if moulded to it, about one-half inch in length by one-fourth of an inch in thickness; and from this another nodule, about the size of a large pea, projected still farther into the orbital tissues. The continuity of the sclerotica between the external and internal tumor was unbroken, it having been infiltrated by the tumor but not ruptured by it. A microscopic section of it showed the characteristic structure of glioma, —viz., numerous small round cells, with large nuclei and scanty protoplasm, imbedded in a finely granular material, each cell being about the size of the granules of the granular layers of the retina.

The child soon returned to the clinic with a button of granulations springing from the bottom of the conjunctival sac. This rapidly increased in size, and, having filled the orbit, projected from the eyelids as a flattened round mass nearly three inches in diameter. Sloughs now formed on the exterior surface of the mass, which separated and fell off, materially reducing its size and allowing the distended eyelids once more to close over it. It, however, soon repullulated.

About this period several lumps appeared on the child's head, and one at the angle of the jaw (left side). Two of these attained considerable size; one near the vertex being a flattened hemisphere about three inches by two in diameter, and the one at the angle of the jaw ulcerating into the cavity of the mouth and causing a constant fetid discharge.

The child, at first very irritable, became heavy and soporose, and died December 14, 1870.

The autopsy showed that the tumors on the outside of the cranium had sprung apparently from the periosteum, leaving, when forcibly pulled off, the bones bare and rough. On removing the calvarium, numerous flattened ovoid lumps were found between the dura mater and the bone, that membrane firmly adhering to them. Some of these were as large as half a walnut. Opposite them were corresponding depressions in the cerebral convolutions. The brain-substance at these points presented no trace of the gliomatous degeneration.

It was also seen that the tumor filling the right orbit had extended backwards through the sphenoidal fissure into the cranium, and, crossing over through the sella turcica, extended to the vicinity of the sphenoidal fissure of the left side.

The case is interesting clinically from its extreme malignancy, and the inefficiency of the operation undertaken at a period when the tumor has filled the ball and caused inflammation and greatly increased intra-ocular pressure, to arrest even temporarily the progress of the disease. Scleral tumors, if small and formed at the posterior surface of the ball, are not to be diagnosticated before enucleation. Having found them, according to many authorities, it is proper to destroy by cauterization the entire contents of the orbit; but the statistics of this procedure were not sufficiently encouraging to cause a decision in favor of so serious an operation.

The prognosis of all such tumors is eminently unfavorable, and the recorded cases in which the return has not been rapid are all instances in which the extirpation was undertaken early. In the foregoing example the yellow reflex from the eyeground had been observed by the parents for nearly a year before they considered it worth while to submit the child to medical examination.

The statistics of the subject have been carefully compiled by Hirschberg.* Out of seventy-seven cases he gives five cures (*i.e.*, 6.5 per cent.). One of these was observed seven years after the operation, one six, and in the other three from one to one and a quarter years had passed without a return of the disease. They were all operated on in the earliest stage of the disease.

I have reported the above history partly in the hope of inducing the members of the Society to use their influence to cause all such cases, as soon as observed, to be carefully examined with the ophthalmoscope, and, if the presence of an intra-ocular tumor be proved by it, to urge instant extirpation. Moreover, they will contribute essentially to the statistics of the subject if they will report the return or metastases of any such cases as fall under their notice. For here, if ever, we have a chance to prove the value of the knife in the treatment of malignant disease. By the ophthalmoscope the disease may be diagnosticated in its very incipiency; and while the abnormal mass measures only a millimetre or two in diameter, and while it is yet shut off from the rest of the organism by the firm fibrous capsule of the

* Der Markschwamm der Netzhaut, Berlin, 1869.

sclerotica, we have surely better means of deciding the question whether malignant disease can be eradicated by the knife, and, if not, whether life can be prolonged by the operation, than is presented to us in any other organ of the body.

II. *Sarcoma of the choroid.*

E. O'C., aged 60, presented herself at the clinic of the University of Pennsylvania, April 1, 1872, with a tumor of the right eye the size of a small hen's-egg. It was everywhere covered by conjunctiva, hard and nodulated. Some years previously an operation for staphyloma had been performed on the eye, and a section of the growth proved that it had its origin in the cicatrix of the shrunken ball.

Microscopic examination showed a network of very small spindle-cells closely felted together, and consequently a comparatively favorable prognosis was made. It was enucleated April 4, 1872, and up to the present date there has been no recurrence.

III. *Sarcoma of the choroid.*

J. H., æt. 25, a healthy-looking farmer, presented himself at the Wills Hospital with a hard lobulated tumor growing from the right eye and pushing the cornea upwards and outwards. The lids can still be closed over it; but it has grown much lately, and causes severe hemicrania. The ball and adherent tumor were removed May 5, 1872. A section of the ball showed the inner wall of it occupied by a *pigmented* tumor, which presented a mottled appearance, owing to some portions of it being less pigmented than others, while some were entirely uncolored. The retina, adherent to the tumor on that side, although pushed inward by it, was on the other side entirely detached from the choroid and separated from it by a mass of pus. The sclera was nowhere ruptured, but outside of it, opposite the choroidal tumor, was an unpigmented hemispherical mass about one-half of an inch in its longest diameter. Microscopic examination showed that the choroid tumor was a small spindle-celled sarcoma, some of the cells pigmented, some with a single nucleus, others with two or three. An examination of the episcleral growth and its edges showed that the fat tissue of the orbit had been irritated by the presence of the neighboring tumor; that the trabeculæ of fibrous tissue pervading it and bounding its areolæ had been hypertrophied, and that then the place occupied usually by the fat-cells had been infiltrated by a mass of small spindle and round cells, resembling those of the original tumor, except in their not being pigmented. This anatomical arrangement, of course, gives a marked areolar appearance to the tumor.

A most unfavorable prognosis was made, which has been only too accurately verified by the course of the case. Within a few days (*i.e.*, about seven months after the removal of the tumor) he has reappeared at the hospital with a recurrence of the growth *in situ*.

Dr. R. M. BERTOLET asked whether in pigmented sarcomata of the choroid, the metastases were also pigmented.

Dr. NORRIS replied that even with regard to sarcomata of the choroid, although the greater number were pigmented, certain tumors occurred which, notwithstanding the marked pigmentation of the mother tissue, were entirely composed of white cells. These are, however, rare. Dr. N. said that metastases were most frequent in the lungs and liver, and that some were pigmented and some not. This circumstance, he said, was claimed by the advocates of each of the two theories as supporting their own view. Those who believe in the metastasis of cells themselves consider the pigmented secondary deposits vindications of their theory; while those who believe in the constitutional origin of morbid growths affirm that their occurrence is evidence in favor of the view that the same cause produces the same effects even in different localities.

Dr. WM. H. BENNETT, for Dr. FRANCIS L. HAYNES, presented the specimens from a case of *intussusception* in an infant five months old.

Thos. M. R., a fine healthy infant, aged five months, was attacked with uncontrollable vomiting on December 25, 1872, at about nine o'clock P.M. The mother administered magnesia and various other remedies; but they were immediately rejected by the stomach. Finally, on the morning of the 27th, I was called in. I found that the child was naturally of a constipated habit, and that no passage had occurred since the evening of the 24th, and then a very insufficient one only. A slight discharge of bloody water had occurred from the bowels on the 25th and 26th. The secretion of urine had been diminished. Upon inspecting and percussing the abdomen, nothing abnormal was discovered, but on making firm pressure in the left lumbar region a cylindrical tumor reaching from the costal margin to the iliac crest, and apparently about one inch and a half in diameter, was found. On introducing the finger into the rectum, a tumor of soft velvety consistence was felt, and having in its centre an oval orifice surrounded by a prominent border. With the assistance of Drs. Knight and Bennett, I passed an elastic catheter up the rectum, and injected as much water as possible, but without any result. Opiates were now administered in small doses and pushed by night to the verge of narcotism, when they were discontinued.

28th, A.M.—The child was suspended by his heels, the tube of a stomach-pump was pushed up the rectum till its extremity could be felt in the descending colon, and forced injections of water made through it by means of a Davidson's syringe. No beneficial result ensued, the water being immediately rejected. Gastrotomy was now proposed. The parents consented, but the operation was not considered justifiable by the consulting physicians. The vomiting, which had continued without cessation until this morning, now ceased. A plentiful supply of milk and brandy was directed to be given to the child. Throughout the day the child suffered from slight paroxysms of pain. Excepting these, his illness was remarkable from the fact that there was an entire absence of apparent suffering. In the evening the measures resorted to in the morning were repeated, but no change was produced.

29th.—In the morning about one ounce and a half of thin dirty-brownish fluid was discharged from the bowels.

Throughout the day the powers of life gradually failed, and at seven o'clock in the evening the child expired.

Autopsy, twenty-two hours after death.—Body frozen, somewhat reduced in flesh. The abdominal cavity only was opened, and the specimen extracted which is now presented for the inspection of the Society.

The specimen was referred to the Committee on Morbid Growths, who reported:

"In Dr. Bennett's specimen of intussusception of the intestine, the invaginated part, measuring twenty-two inches, comprises the ascending and transverse portions of the colon. The cæcum seems to have been the starting-point of the invagination, which, being inverted and descending along the colon, drew after it several inches of the ileum with its mesenteric attachment. Between the two serous surfaces of entering and returning layer were found evidences of inflammatory thickening with slight adhesions."

(To be continued.)

A CALL DECLINED.—Prof. Max von Pettenkofer declines to leave Munich for Vienna, to the great disappointment of all connected with the school in the latter city.

REVIEWS AND BOOK NOTICES.

WÖHLER'S OUTLINES OF ORGANIC CHEMISTRY. By RUDOLPH FITTIG, Ph.D., Nat. Sci. D. Translated from the Eighth German Edition by IRA REMSEN, M.D., Ph. D., Professor of Chemistry in Williams College, Mass. Pp. 547. Philadelphia, Henry C. Lea, 1873.

The value of this work to the student of chemistry is undoubted, as indeed might be imagined from the reputation of its distinguished author, and the number of editions through which it has passed.

Beginning with a short account of those properties common to most organic compounds, and of certain of the terms commonly used in classifying and describing them, the author passes in review most of the very numerous compounds hitherto investigated, describing particularly the most typical and important in each group, but saying all that is necessary with regard to the others. To add to the value of the work in the eyes of the student of medicine, fifty pages at the end are devoted to those substances which could not be readily considered elsewhere, such as the bile, the blood, etc.

The American editor has prefixed a chapter on the constitution of chemical compounds, for the benefit of those who may not be familiar with the theories in accordance with which the book has been arranged.

GLEANINGS FROM OUR EXCHANGES.

THE DEATH OF NAPOLEON III. THE POST-MORTEM EXAMINATION—THE OFFICIAL REPORT.—The post-mortem examination of the ex-Emperor took place on the 10th inst. It was performed by Dr. Sanderson, in the presence of Sir William Gull, Dr. Conneau, Dr. le Baron Corvisart, Sir Henry Thompson, Mr. Clover, and Mr. Foster. The examination occupied upwards of two hours, and the following is the official report:

"The most important result of the examination was that the kidneys were found to be involved in the inflammatory effects produced by the irritation of the vesical calculus—which must have been in the bladder for several years—to a degree which was not suspected, and if it had been suspected could not have been ascertained.

"The disease of the kidneys was of two kinds. There was, on the one hand, dilatation of both ureters and of the pelves of both kidneys. On the left side the dilatation was excessive, and had given rise to atrophy of the glandular substance of the organ; on the other there was subacute inflammation of the uriniferous tubes, which was of more recent origin. The parts in the neighborhood of the bladder were in a healthy state; the mucous membrane of the bladder and prostatic urethra exhibited the signs of subacute inflammation, but not the slightest indication of injury. In the interior of the bladder was found a part of a calculus, the form of which indicated that half had been removed. Besides this there were two or three extremely small fragments, none of them larger than a hempseed. This half-calculus weighed about three-quarters of an ounce, and measured one-quarter of an inch by fifteen-sixteenths of an inch.

"There was no disease of the heart, nor of any other organ, excepting of the kidneys. The brain and its membranes were in a perfectly natural state. The blood was generally liquid, and contained only a very few small clots. No trace of obstruction by coagula could be found either in the venous system, in the heart, or in the pulmonary artery. Death took place by the failure of the circulation, and was attributable to the general constitutional state of the patient.

"The disease of the kidneys, of which this state was the expression, was of such a nature and so advanced that it would in any case have shortly determined a fatal result.

"(Signed by all present.)

J. BURDON SANDERSON, M.D.,
DR. CONNEAU,
DR. LE BARON CORVISART,
HENRY THOMPSON,
J. T. CLOVER,
JOHN FOSTER.

"CAMDEN PLACE, CHISELHURST, Jan. 10, 1873, 6.30 P.M."

Sir William Gull left Camden Place as soon as the necropsy was over, and was not present at the careful consideration and discussion of the facts which ensued by the other medical men assembled. He records a separate opinion on one point only,—the origin of the calculus,—in the following terms:

"I desire to express the opinion that the phosphate of lime calculus which formed the nucleus of the mass was the result of prior cystitis (catarrhus vesicæ), and not the cause of it. This nucleus was of uncertain duration, and may even have been more recent than supposed in the appended report. However this may be, it was encrusted by two distinct and more recent formations of crystalline phosphate. The inner incrustation around the amorphous phosphate of lime was dense, and separated from the outer incrustation by a looser cellular but crystalline deposit of triple phosphate. It seems, to my judgment, more in accordance with clinical experience to regard the cystitis as the prior lesion, and that, by extension, as is common in such cases, it affected subsequently the ureters and pelves of the kidneys. No doubt, in the later stages of the malady, the calculus became, by its formation and increase, an augmenting cause of lesions.

"The other facts and statements I entirely indorse.

"WILLIAM W. GULL, M.D.

"BROOK STREET, January 10, 1873."

THE SO-CALLED CORPORA AMYLACEA IN THE MEMBRANOUS SEMICIRCULAR CANALS OF MAN (A. Lucæ: *Virchow's Archiv*, Band 54, Heft 4, 1872).—In this article Prof. Lucæ reiterates his conviction that certain bodies found in the membranous semicircular canals of man are of a pathological nature and are peculiar to the adult human being.

These bodies are never found in the new-born child, but, according to Lucæ, are produced, in some instances, by local disturbances; in others they are the result of general systemic disease. The name *corpora amylacea* is still applied to these bodies by Lucæ, since their starchy nature is said to be proved by the characteristic reaction manifested by them in the presence of iodine. They are found in gray degeneration of the spinal cord, typhus and typhoid fever, tumor of the brain, tuberculosis, morbus Brightii, chronic ulcer of the stomach, and in cases where a disease of the ear—as, for example, otitis media—has been present up to the time of death.

These bodies are not found in the lower mammals, birds, fishes, or amphibia, according to all observers.

Prof. Rüdinger opposes Prof. Lucæ on all points save the last.

He says that the reason these bodies are found in the above-mentioned diseases is due to the fact that these diseases supply the anatomist with his material, and, as they are normal structures, they must necessarily be found in all adult subjects, and their occurrence in such cases is rather *post hoc* than *propter hoc*. Rüdinger considers them "papilliform prominences on the inner surface of the tunica propria of the membranous semicircular canal." And he adds, "I must consider them normal structures of the adult human being, since I have never failed to find them, in some stage of

development at least, in man. So far as their reaction with iodine is concerned, they share that characteristic with the tunica propria and other tissues in which no starch can be shown to exist; and, furthermore, the epithelium with which these bodies are covered, but the existence of which Lucæ has denied, can be readily shown by the proper application of the necessary reagents."

Concerning their function, Rüdinger says,—

"If we dare suppose that the membranous semicircular canals secern the endolymph, these papillæ would appear to be structures eminently calculated to supply a large secreting surface." C. H. B.

DOUBTFUL SEX (Tardieu: quoted from *Centralblatt für Med. Wiss.*, No. 45, 1872).—In a memoir on the medico-legal aspect of cases of doubtful sex, the author relates the following: A man married a person whose genitals were not normally constructed. Although he soon discovered that the individual did not belong to the female sex, he did not attempt to institute a suit for divorce on the plea of invalidity of marriage. The person in question possessed no mammæ, and its pelvis was more like a man's than a woman's. There was no vagina, no uterus, no ovary, nor had there ever been (twenty-seven years) any menstrual flow of blood, nor any periodical pains: only the external genitals, in consequence of excessive hypospadias, could give the impression of appertaining to a female. Since, according to the French law, impotence or malformation of an individual of undoubted sex can be no impediment to marriage nor cause of divorce, and since, on the other hand, a marriage between persons of the same sex cannot be consummated, and where it may have occurred by accident is of itself null and void, the great question in this case was whether the person under consideration should be regarded as a woman with abnormally formed genitals, or whether *she* should be regarded as a man. The first trial decided the marriage to be illegal, on the latter alternative, after a careful medico-legal examination. The so-called wife appealed from this decision, and procured a medical certificate stating that she must be considered a female from the structure of the external genital organs. Finally Tardieu was called upon for his opinion, which was as follows. Since this person was not the possessor of the essential organs of a female, uterus and ovaries, said person cannot belong to the female sex; but, since similar cases show that persons with just such abnormal genitals are provided with testicles, though diminutive and hidden, therefore they must be regarded as belonging to the male sex. And the verdict was rendered accordingly.

MISCELLANY.

THE late Mr. James Startin, F.R.C.S., was one of the leading dermatologists in London, and had a very large practice. His name was well known to the profession in this country some twenty years ago, from his advocacy of a so-called "immovable dressing" for fractures, his idea being to apply bandages and subsequently to stiffen them with stearine. The "paraffine bandage" now used by many English surgeons is very analogous to this.

IT is stated that, on motion of the Earl of Derby, the residue of the fund raised for the sufferers by the cotton famine is to be applied to the foundation of a hospital at Manchester.

DEATH-RATE OF BOSTON.—By the annual report of the State Board of Health, it appears that the mortality of Boston in 1872 has been unprecedented. The deaths in 1872 exceeded those of 1871 by 37 per cent., exclusive of those from smallpox, the increase of which has been 25 per cent.

YELLOW FEVER AT RIO DE JANEIRO.—Telegraphic advices from Lisbon, dated January 28, announce that the mail steamship from Rio de Janeiro, on the 11th instant, brought intelligence that the yellow fever was raging in Rio at the date of her departure.

THE *Lancet* of January 4 says, "Robin and Littré have submitted to the Academy of Sciences the new edition of their Dictionary of Medicine. Robin points out that the work is based on philosophical principles. Pathology he considers as a branch of biology which levies contributions on mathematics, chemistry, physics, and even social science and history. The Archbishop of Orleans has denounced the Dictionary as tending to lower man to the level of the brutes."

THE HISTORY OF MEDICINE (*Lancet*, Jan. 4).—Dr. Ollivier, Deputy Professor at the Faculty of Medicine of Paris, will this session lecture in the room of the lamented Dr. Daremberg. The introductory discourse of this talented member of the Faculty was published in *L'Union Médicale*, December 10 and 12, 1872. The lecturer, after paying a well-deserved tribute to his predecessor, showed how important it is for medical men to have some notions as to what has been done before them. This knowledge should be especially possessed by those who write on our art. Dr. Ollivier, as an illustration of this, quotes two examples,—one concerning the transformation of starch into glycose by the action of the saliva, supposed to be a modern discovery: whilst Verheyen mentions it very clearly in his "Supplementum Anatomicum," published in 1710, p. 113. Here is the text: "Ut verò certiùs experire vim fermentivam salivæ, accepi duas partes farinæ tritici, earum alteram subegi cum meâ salivâ alteram cum aquâ vulgari leniter calefactâ; cumque utramque massam tenuissem in blando calore duarum circiter horarum spatio, inveni illam, quæ cum humore salivali erat subacta, itâ fermentatam, ac si flores cerevisiæ fuissent additi; alteram verò quoad sensum non mutatam." The second example refers to the use of the thermometer in acute diseases,—a practice lately revived, and thought by some to be quite modern. De Haen, however, had already noticed, as is now frequently observed, that in the shivering stage of fever the temperature is, nevertheless, very high. He says, in his "Ratio Medendi," published in 1761, "Tempore frigoris humani intolerabilis, cum pulsu contractiore, minore, thermometrum signat octo graduas ultra calorem naturalem" (vol. i., second part, chap. x. p. 205). The eight degrees seem much; but this is owing to De Haen's belief that the column of mercury still rises when it has left the axilla. The lecturer then referred to what are called new diseases and extinct diseases, took an extended view of the epidemics of ancient

times, and concluded with remarks on cholera and syphilis viewed as epidemic complaints.

THE SALE OF DIPLOMAS.—The *American Chemist* for January, 1873, says, "In the *Literarischer Anzeiger* we notice an advertisement of this disgraceful business, which has been legally suppressed by the Legislature of Pennsylvania. The publishers of the above scientific periodical must be in a condition of great poverty, that they are so lost to a sense of honor as to receive such an advertisement. The commissioners of charities should give them their attention."

BARON STOCKMAR, for very many years an influential personage in European diplomacy, whose memoirs have recently been published in English, began life as a physician, and practised as a civil and military surgeon for six or seven years. His appointment as physician-in-ordinary to Prince Leopold gave him an introduction into court circles, where he played an important part, especially in England.

CHARITY HOSPITAL OF PHILADELPHIA.—Drs. Deal and Kollock have recently been elected to fill the department of Diseases of Women and Children at this institution. Dr. Barton has been transferred from the medical to the surgical staff.

UNSUCCESSFUL CANDIDATES.—After a recent examination of female teachers in Ohio, some of the unsuccessful candidates complained that injustice had been done them, whereupon the examiners were so cruel as to publish extracts from the papers written by the rejected applicants. The following are a few specimens of the answers: "The food is first masticated and then passes through the phalanx;" "Respiration is the sweating of the body;" "The chest is formed of two bones, the sternum and the spinal cord."

A FOREIGN vegetarian, who came to this country with the intention of introducing unbolted flour, has given it up as impracticable, because, as he asserts, the Americans give such little time to their meals that they bolt everything they eat.

APPOINTMENT.—Governor Hartranft has appointed Dr. W. A. Hoffman Port Physician for Philadelphia. Our very efficient Health Officer, Mr. John E. Addicks, will be retained in his position.

IT is stated that Miss Sophia Jex Blake, the head and front of the female aspirants for medical honors at the Edinburgh University, came up for examination recently, but failed to pass, or, in British student phrase, was "plucked."

PRESBYTERIAN HOSPITAL DISPENSARY.—The Trustees of the Presbyterian Hospital, desirous to extend their benefits to the poor of West Philadelphia, have established a dispensary on Thirty-ninth Street, below Powelton Avenue. They have appointed Dr. De F. Willard as Surgeon, and Dr. G. S. Gerhard as Physician, both of whom will hold clinics daily at half-past one o'clock P.M.

NOVEL CURRENCY.—The London *Chemist and Druggist* says, "An American friend assures us that in South Bend, Indiana, they use small packages of quinine for change. As everybody takes quinine, they look upon it the same as legal tender, and it passes off without difficulty."

M. LITTRÉ, the greatest of medical scholars, has completed his dictionary of the French language,—one of the most remarkable feats of the century. The work is especially rich in its etymology and definition of medico-scientific terms.

MORTALITY OF PHILADELPHIA.—The interments reported at the Health Office for the week ending February 1, 1873, were 333; 166 adults, and 167 minors. 12 were of bodies brought from the country; making the mortality of the city 321. Among the causes of death were:

Consumption of the Lungs	48
Other Diseases of the Respiratory Organs	56
Diseases of the Circulatory Apparatus	14
Diseases of the Brain and Nervous System	47
Diseases of the Digestive Apparatus	15
Zymotic Diseases (11 from Scarlet Fever)	27
Typhoid Fever	9
Casualties	8
Exposure	2
Cancer	6
Intemperance	4
Suicide	1
Debility (including "Inanition" and "Marasmus")	31
Still-born	26
Old Age	15

(The interments reported for the week ending February 3, 1872, were 437.)

THE meteorological record kept at the Pennsylvania Hospital was as follows:

	THERMOMETER. Max.	Min.	BAROMETER. (2 P.M.)
Jan. 26	32.5°	21.5°	30.33 in.
" 27	36.0	28.0	29.86 in. (Snow.)
" 28	41.0	20.0	30.20 in.
" 29	16.5	3.0	30.48 in.
" 30	17 0	2.0	30.35 in.
" 31	31.5	8.0	30.34 in.
Feb. 1	34.0	17.0	30.23 in.

The mean temperature of the month of January was 29.68°, or 1.15° lower than that of January, 1872 (30.83°); and yet the latter was noted as an unusually cold month.

OFFICIAL LIST

OF CHANGES OF STATIONS AND DUTIES OF OFFICERS OF THE MEDICAL DEPARTMENT U.S. ARMY, FROM JANUARY 21, 1873, TO JANUARY 27, 1873, INCLUSIVE.

MCMILLIN, THOMAS, ASSISTANT-SURGEON.—To accompany batteries of Fourth Artillery, under orders for field-service in Oregon. S. O. 5, Department of California, January 10, 1873.

WEISEL, D., ASSISTANT-SURGEON.—Assigned to duty at Fort Johnston, N.C. S. O. 14, Department of the South, January 22, 1873.